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Physician assisted death should be available to people with MS – “No”.

No one doubts that MS can be a uniquely awful disease. But it is not unique in relation to assisted dying. An argument attempting to justify physician-assisted death *only* for people with MS is surely unsustainable. And so this ‘Controversy’ is in fact whether physician-assisted death should be available at all. I will argue that the ‘goods’ supporting physician-assisted death are substantially less clear-cut than they might appear; and that the consequences – for patients, for society, and for medicine – are as predictable as they are completely unpreventable.

The arguments in favour are clearly well-intentioned. They are essentially two: autonomy, the right of an individual to make his or her own decisions; and the prevention of suffering. Autonomy is clearly a ‘good’. But can it extend to a ‘right to die’? Can a right to die mean anything other than a general right to suicide – a right that logically must extend to anyone with capacity? (How would this affect ED staff, for example, dealing with Friday night overdoses?) In truth, we do not recognise a right to suicide: in the UK, the 1961 Suicide Act rendered attempted suicide no longer a criminal act but, as has been repeatedly stressed, “conferred no *right* on anyone to commit or attempt to commit suicide¹” [my emphasis]. The key principle is that while autonomy is a good, it is not a moral absolute, trumping all other considerations. Some ‘freedoms’ and personal choices, from not wearing a seat-belt to the sale and purchase of drugs between consenting adults, are legally constrained in the interests of society or for the greater good.

As for the relief of suffering, the question must be asked, is intentionally ending the life of the individual an appropriate response to suffering? And is euthanasia, in any of its formulations, really necessary for this purpose? Palliative care does work in the great majority of cases. And altering the law, and reversing a fundamental tenet of medicine, for the sake of the small number of individuals in whom it has not sufficiently helped, no matter how emotional their stories may be, carries too many risks.

Proponents of assisted dying argue that there need be no ‘slippery slope’, and there are no dangers of legalisation that could not be prevented. But this is no longer a ‘live’ argument. Assisted dying having been introduced – and monitored – in various countries or states, the evidence is in. The results are not ambiguous: despite the best intentions, and the best possible regulation, assisted dying always extends beyond those for whom it was originally intended, often dramatically.

Oregon, it is often claimed, is watertight in its controls, with a ‘quadruple lock’ to prevent any hint of a ‘slippery slope’. But the lock is no such thing: every one of the four components is fragile : -

[1] *this will only apply in individuals with terminal illness and less than 6 months to live.* But we as doctors are useless at predicting death! In Oregon itself, there are (already) records of patients ‘approved’ for assisted dying, who changed their mind, and were still alive for up to 3 years later. As the (UK) Royal College of General Practitioners has said, “It is possible to make reasonably accurate prognoses of death within minutes, hours or a few days. When this stretches to months, the scope for error can extend into years.”²

[2] *individuals must be of ‘sound mind’ – both competent, and not clinically depressed.* A BMJ study in 2008 retrospectively examined the records of 18 Oregon patients, and found 1 in 6 showed evidence of clinical depression. In Oregon, the proportion of people referred for psychiatric evaluation prior to PAS decreased from 37% in 1999 to less than 3% in 2013³ –

the threshold of caution changes. The same trend is seen in psychiatric assessment in Holland.

[3] *two doctors, not one, must sign the relevant forms.* The difficulty here is that only very few doctors are advocates willing to carry out assisted dying. In 2010, just 56 physicians wrote ALL the PAS prescriptions in Oregon, out of ~9,000 practising doctors there. It can hardly be difficult for one doctor to find another to 'sign the form'.

[4] *there must be no coercion.* But there is no detail about how this is to be prevented – because it cannot. The impossibility lies in the fact that coercion is commonly internally perceived by the suffering individual, knowing the inconvenience and cost she or he is putting their relatives to, rather than crudely applied.

It is then no surprise that, in approving states, numbers continue steadily to increase. Belgium – where a population-based survey found that almost a third of cases “were without explicit request by the patient”⁴ – has legalised assisted dying for minors and more recently for clinically depressed and/or psychiatrically ill individuals. Holland accepts euthanasia for infants (the 'Groningen protocol')⁵ – not just the terminally ill, but babies for whom a 'poor quality of life is predicted'.

What of the wider implications? Self-evidently, assisted dying undermines palliative care – virtually all medical bodies have majorities against the procedure, but that majority is highest amongst palliative care specialists. But more than this, it undermines the general practice of medicine. As the GMC has said, “A change in the law to allow physician-assisted dying would have profound implications for the role and responsibilities of doctors and their relationships with patients. Acting with the primary intention to hasten a patient’s death would be difficult to reconcile with the medical ethical principles of beneficence and non-maleficence.”⁶ Medicine cannot be properly practiced unless patients trust doctors, and doctors cannot inspire and do not deserve that trust unless patients believe that doctors have neither the inclination nor a legal requirement, to ask if the patient is the kind of human being who is worth caring for or treating. Those who most fear and who are most opposed to assisted dying are the elderly, and the physically and mentally ill (those most likely to support are white, male, wealthy, educated, and in good health – aside from ‘progressive’ philosophers such as Baroness Warnock: “If you’re demented, you’re wasting people’s lives – your family’s lives – and you’re wasting the resources of the National Health Service”⁷).

This is a difficult and emotionally charged debate. The vast majority of those campaigning in favour of assisted dying obviously intend nothing but kindness, and the relief of suffering. But, to quote Milton Friedman, “one of the great mistakes is to judge policies and programmes by their intentions rather than their results”. The results of making physician-assisted death available to people with MS would be truly regrettable.

- 1 Lord Bingham in *Regina (Pretty) v. Director of Public Prosecutions* (2001), p.
- 2 Vol. Select Committee on Assisted Dying for the Terminally Ill Bill Minutes of Evidence
- 3 in *Oregon Health Authority: Public Health*.
- 4 Chambaere, K. *et al.* Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne* **182**, 895-901, doi:10.1503/cmaj.091876 (2010).
- 5 Verhagen, E. & Sauer, P. J. The Groningen protocol--euthanasia in severely ill newborns. *The New England journal of medicine* **352**, 959-962 (2005).
- 6 Vol. Select Committee on Assisted Dying for the Terminally Ill Bill Minutes of Evidence
- 7 Beckford, M. in *Daily Telegraph* (2008).